Form 102-CWP
Adopted 7/02

KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
Application for Resolution of Coal Workers' Pneumoconiosis Claim
Claim No. _____

..... **Plaintiff**	**vs.**	..... **Defendant/Employer**
..... **Social Security Number**		..... **Street Address**
..... **Birth Date**		..... **City/State/Zip Code**
..... **Street Address**		..... **Insurance Carrier**
..... **City/State/Zip Code**		..... **Street Address**
..... **County**		..... **City/State/Zip Code**

Filed:

..... **Other Defendant**

..... **Street Address**

..... **City/State/Zip Code**

Reason for Joinder:

....

.....

..... **Other Defendant**

..... **Street Address**

..... **City/State/Zip Code**

Reason for Joinder:

.....

.....

I. Nature of Occupational Disease

1. Plaintiff states that on the ..... day of ....……..., 20....., (day) (month) (year) he/she became affected by coal workers' pneumoconiosis arising out of and in the course of his/or her employment.

2. State the date and means by which plaintiff gave notice of the injury to employer.

_____

3. Place of last exposure:

(city) (county) (state)

4. Nature of the work in which the plaintiff was engaged at the time of exposure

_____

5. How did exposure to the disease occur? (Describe in detail)

_____

II. Personal Data

6. Name and address of last school attended: _____
7. Highest grade completed in school: _____
8. GED awarded: _____ yes _____no
9. Professional or vocational degrees, certificates, or licenses: _____

_____

10. Dependents: Name Social Security Number Relationship

11. Has plaintiff previously filed a claim for Kentucky coal workers' pneumoconiosis benefits (including retraining incentive benefits)? ___yes ___no
If yes, give the date and defendant in previous claim: _____

_____

III. Employment Data

12. Weekly wage at date of last exposure: _____
Attached copy of any proof wages, such as paycheck stub, W-2, etc.

13. Is plaintiff currently employed? ___ yes ___no
Name and address of current employer : _____

_____

14. Is plaintiff still working in an environment where he/she is exposed to the hazards of the disease ? ____ yes ____ no

15. Number of years of exposure to hazards of occupational disease

16. Has plaintiff been exposed to the disease while working for more than one employer?
____ yes ____ no

17. Weekly wage currently earned: _____ Attach copy of any proof of current wages.

IV. Medical Data

18. List name and address of "B" reader whose report is attached to this Form. File original x-ray read by this "B" reader with this form.

Name of "B" Reader	Address

19. Are you alleging a pulmonary impairment as the result of coal dust exposure?
_____ yes _____ no
If yes, attach results of pulmonary function studies and tracings.

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Plaintiff herein being duly sworn, states that the statements in this application and in Form 104, 105, and 106 are true. This the _____ day of _____ 20____.

_____
Plaintiff's Signature

Subscribed and sworn to before me this _____ day of _____ 20___.

_____
Notary Public

My Commission expires: _____ County: _____

Prepared and submitted by: _____
Signature of Attorney for Plaintiff

_____
Name of Attorney (Print or Type)

_____
Street Address

_____
City/State/Zip Code

_____
Telephone Number

Instructions for
Completion of Forms 101, 102, 102-CWP and 103

Form 101 - Application for Resolution of Injury Claim

1. All sections of this form must be completed, and must be accompanied by the following:
   a. Form 104 (Plaintiff's Employment History)
   b. Form 105 (Plaintiff's Chronological Medical History)
   c. Form 106 (Medical Waiver and Consent)
   d. Medical report describing and supporting the injury which is the basis of the claim
   e. Proof of Wages, including W-2's, paycheck stubs, etc.

2. All information must be typewritten.

3. File the original of this form and sufficient copies for all named defendants with the Department of Workers' Claims, Prevention Park, 657 To Be Announced Ave., Frankfort, Kentucky, 40601.

4. If you have no telephone number, please list a number at which you may be contacted.

5. If you have questions, call 1-800-554-8601.

Form 102 & Form 102-CWP - Application for Resolution of Occupational Disease Claim, and Form 103 - Application for Resolution of Hearing Loss Claim

1. All sections of this form must be completed, and must be accompanied by the following:
   a. Form 104 (Plaintiff's Employment History)
   b. Form 105 (Plaintiff's Chronological Medical History)
   c. Form 106 (Medical Waiver and Consent)
   d. Medical report of "B" reader supporting the disease. (Applies to 102-CWP only)
   e. Original x-ray read by "B" reader (Applies to 102-CWP only)
   f. Pulmonary function studies and tracings if a pulmonary impairment is alleged
   g. Proof of Wages, including W-2's, paycheck stubs, etc.
   h. Social Security earnings record release form

2. This form may be filed in combination with an Application for Resolution of Injury Claim (Form 101) if both benefits are sought. Information provided should be current through the date application is signed by plaintiff.

3. All information must be typewritten.

4. File the original of this form and sufficient copies for all named defendants with the Department of Workers' Claims, Prevention Park, 657 To Be Announced Ave., Frankfort, Kentucky, 40601.

5. If you have questions, call 1-800-554-8601.

Note: Please list the correct name and address of the employer and insurance carrier to avoid delay in processing the claim.

Revised July, 2002